girl scouts

Girl Scouts of California's Central Coast

HEALTH HISTORY RECORD

To be completed, signed by parent/guardian, and updated annually.

Name_____ Date of Birth_____ Age_____
Address_____ Troop No._____
Parent/Guardian_____ Phone_(_____)_____
Home Address_____
Business Address_____ Phone_(_____)_____

In Emergency Notify:

Name_____ Relationship_____
Address_____ Phone_(_____)_____
Name of Family Physician_____ Phone_(_____)_____
Family Medical Hospital_____ Address_____
Insurance Carrier_____ Group No._____ Member No._____

Racial/Ethnic Information (Optional information to assist in serving our diverse community.)

Spanish/Hispanic____ American Indian/Alaskan Native____ Asian/Pacific Islander____ Black____ White____ Other____

Part I: Illnesses and Injuries (Check all that apply and give appropriate dates.)

Chronic or Recurring Illness:

____ Ear infection ____ Bleeding/clotting disorders ____ Hypertension ____ Asthma
____ Heart defect/disease ____ Musculoskeletal disorders ____ Seizures ____Diabetes
____ Other (specify)_____

Date of last health examination?_____
Were any complicating medical problems noted in last health examination?_____
Are you currently under the care of a physician or psychologist?_____
Since last health exam, have you had:

a serious injury requiring medical attention? _____ an illness lasting more than five days? _____
any prescribed or over-the-counter medication? _____ a surgical operation or fracture? _____
treatment in a hospital or emergency room? _____ any restrictions concerning physical activities? _____
any exposure to a contagious disease? _____

Please explain any "yes" answers to the above questions (include dates).

Part II: Allergies (Check all that apply and specify nature of allergic reaction.)

__ Animals_____ __ Hay fever_____
__ Pollen_____ __ Food_____
__ Plants_____ __ Insect stings_____
__ Medicines/drugs_____
__ Other (specify)_____

Part III: Other Health Conditions (Check all that apply.)

__ Bed wetting __ Emotional disturbances
__ Constipation __ Fainting
__ Menstrual cramps __ Hearing impairment
__ Motion sickness __ Sickle cell trait or disease
__ Nosebleeds __ Special dietary regimen
__ Sleep disturbances __ Wears glasses or contacts
__ Other (specify)_____

Please explain any items that are checked. Indicate any information useful to the person in charge in relation to any of these health conditions. Also, indicate any activities to be restricted:_____

Part IV: Immunization History

Immunization	Year Primary Series Completed	Year of Last Booster
Hep B		
DTap/Tdap		
DT/Td		
Hib		
IPV/OPV		
PCV7		
MMR		
Varicella		
Other		

Tuberculin test (result of most recent)_____

Parent Consent:

In the event of an emergency, every effort will be made to contact a parent or emergency contact. If no contact can be made, I hereby give authorization to Girl Scouts of California's Central Coast to seek treatment for my child or myself by a licensed physician under the Medical Practice Act, pursuant to Section 25.8 of the California Civil Code.

Signature of Parent/Guardian_____

Date_____